Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

VISTA HOSPITAL OF DALLAS
4301 VISTA ROAD
PASADENA TX 77504

Respondent Name

DALLAS ISD

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-05-1109-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "In this instance, the patient was admitted for three days for surgical inpatient services. Therefore, in accordance with the formula, the WCRA is 3 X $1118.00 = $3,354.00. The prior amounts paid by the carrier were $1118.00. Therefore, the Carrier is required to reimburse the remainder of the Workers' Compensation Reimbursement Amount of ($3,354.00-$1,118.00) = **$2236.00, plus interest**."

Amount in Dispute: $2,236.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "I am attaching pre-authorization for 1 day stay. Based on review by Argus we do not owe additional money. No additional payment is being made."

Response Submitted by: Dallas ISD, 3700 Ross Ave., Box 91, Dallas, TX 75204

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
February 4, 2004 through February 7, 2004	Inpatient Services	$2,236.00	$2,236.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.401, effective August 1, 1997, 22 TexReg 6264, sets out the

reimbursement guidelines for inpatient hospital services.

3. This request for medical fee dispute resolution was received by the Division on October 14, 2004. Pursuant to 28 Texas Administrative Code §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on October 18, 2004 to send additional documentation relevant to the fee dispute as set forth in the rule.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - F1-TWCC Code: F-Fee guideline MAR reduction.
   - Charge exceeds the schedule maximum allowance per the Medical Fee Guideline.
   - G90-TWCC Code: G-Unbundling (Included in Global)
   - The value of this service is included in the value of another service billed on the same date.
   - 01-TWCC Code: O-Denial after reconsideration.
   - Upon review of your request for reconsideration, no additional benefit is recommended.

Findings

1. The respondent states in the position summary that "I am attaching pre-authorization for 1 day stay. Based on review by Argus we do not owe additional money. No additional payment is being made." 28 Texas Administrative Code §133.307(j)(2) states "The response shall address only those denial reasons presented to the requestor prior to the date the request for medical dispute resolution was filed with the division and the other party. Responses shall not address new or additional denial reasons or defenses after the filing of an request. Any new denial reasons or defenses shall not be considered in the review." The Division finds that based upon the submitted explanation of benefits the respondent did not raise the issue of preauthorization prior to the date the request for medical dispute resolution was filed; therefore, the preauthorization issue will not be considered in this review per 28 Texas Administrative Code §133.307(j)(2).
2. This dispute relates to inpatient medical services provided in a hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.401.
3. 28 Texas Administrative Code §134.401(b)(1)(B), states "Inpatient Services – Health care, as defined by the Texas Labor Code §401.011(10), provided by an acute care hospital and rendered to a person who is admitted to an acute care hospital and whose length of stay exceeds 23 hours in any unit of the acute care hospital."

   A review of the submitted medical bill and itemized statement, indicate that the requestor billed for three (3) inpatient surgical day; therefore, this admission meets the definition of inpatient services per 28 Texas Administrative Code §134.401(b)(1)(B).
4. 28 Texas Administrative Code §134.401(c)(1) states "Standard Per Diem Amount. The workers' compensation standard per diem amounts to be used in calculating the reimbursement for acute care inpatient services are as follows: Surgical $1,118."
5. 28 Texas Administrative Code §134.401(c)(3)(B), the reimbursement calculation formula is "LOS X SPDA = WCRA." Therefore 3 multiplied by $1,118.00 = $3,354.00.

   A review of the submitted EOBs supports reimbursement of $1,118.00 for inpatient surgical services; therefore, the requestor is due the difference between $3,354.00 and $1,118.00 = $2,236.00 in accordance with 28 Texas Administrative Code §134.401(c)(1) and (c)(3)(B).

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports the reimbursement amount sought by the requestor. The Division concludes that the requestor has supported its position that additional reimbursement is due. As a result, the amount ordered is $2,236.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $2,236.00 plus applicable accrued interest per 28 Texas Administrative Code §134.803, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	1/04/2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.